

Registration District No. 138

Primary Registration District No. 4078

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Norborne, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Gola Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Seven Days.
(Specify whether
In this community 48. Years.
years, months or days)

3. (a) PRINT
FULL NAME

Fred Goetting.

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex

Male

5. Color or

race White

6. (a) Single, widowed, married,
divorced Married

6. (b) Name of husband or wife

Minnie Goetting.

6. (c) Age of husband or wife if
alive 60 years

7. Birth date of deceased

March
(Month)

28
(Day)

1980
(Year)

8. AGE:

Years

Months

Days

If less than one day

61

2

27

hr.

min.

9. Birthplace

Redbud Illinois.

(City, town, or county)

(State or foreign country)

10. Usual occupation

Farmer.

11. Industry or business

12. Name

Fred Goetting.

13. Birthplace

Redbud, Illinois.

(City, town, or county)

(State or foreign country)

14. Maiden name

Sophia

Stellhorn

15. Birthplace

Redbud Illinois.

(City, town, or county)

(State or foreign country)

16. (a) Informant

F. B. Goetting

(b) Address

3817 Pittman St. Norborne Mo

17. (a)

Burial

(b) Date thereof

6-29, 1941

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Luthana Cemetery.

18. (a) Signature of funeral director

John A. Hite

(b) Address

Norborne Mo

19. (a)

6-28-41

(b)

Reginald M. D.

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
(c) City or town Norborne Mo. Rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? American years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6-27-1941
year hour minute 10 30 0 M.

21. I hereby certify that I attended the deceased from 3-4-40
1940 to 6-27- 1941
that I last saw him alive on 6-27- 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Encephalitis
Anterior Meningitis
Dissection of Aorta

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place)
(e) Means of injury

23. Signature B. C. Cole (M. D. or other)
Address Norborne Mo Date signed 6-28-41

134
RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-8-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

working under my personal supervision. _____, Registered Apprentice No. _____

Signed

John G. Deitch

Licensed Embalmer No. 3654

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21367

Registration District No. 138

Primary Registration District No. 4078

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Carroll
(b) City or town Corborne
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Fred. Guetting

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 61 Months 2 Days 27 If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 27 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

- that last saw him alive on _____, 19____;

- and that death occurred on the date and hour stated above, _____

- Immediate cause of death acute Bright's disease followed chronic Bright's arteriosclerosis Dilatation of Heart

- Due to _____

- Due to _____

- Other conditions _____

- (Include pregnancy within 3 months of death)

- Major findings: _____

- Of operations _____

- Of autopsy _____

- _____

- _____

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- _____

- _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____ (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

- _____

- _____

- _____

- _____

- _____

- _____

- _____

- _____

- _____

- _____

